State of Nebraska

Medicaid Provider ACH/EFT Enrollment Form MS-84 Instructions

The following instructions are provided to assist Medicaid Providers to accurately complete and submit the Nebraska Medicaid Provider ACH/EFT Enrollment Form, MS-84.

- Electronic Fund Transfer (EFT) enrollment is required for a provider to enroll with Nebraska Medicaid.
- Medicaid providers must submit this form to receive payment via EFT (Electronic Fund Transfer). It is also the responsibility of the Medicaid provider to ensure this information is updated, as necessary.
- Nebraska Medicaid transmits the EFT via the NACHA standard CCD+ format.
- It is the responsibility of the Provider to contact their financial institution to request the receipt of all data contained within the ACH information field (including the TRN Reassocation Trace Number) of the CCD+ Addenda Record. This Trace Number uniquely identifies the transaction set and aids in reassociating payments and remittance advices.
- When enrolling for multiple provider numbers/entities, please complete separate ACH/EFT Enrollment Forms for each.

NOTE:

- Follow specific instructions for fields displayed in **BOLD** font.
- The completed form and required attachments can be submitted via secure email, fax or mail.
- Required elements are indicated with an **asterisk**.

Medicaid-assigned Provider Number	Enter the 11-digit provider number assigned by Nebraska Medicaid. If not previously enrolled in Nebraska Medicaid, leave blank.
Bank Location	Check the box if bank is located outside the US. No payment can be made to a financial institution located outside the US.

PROVIDER INFORMATION	
DATA ELEMENT NAME	DESCRIPTION
Provider Name*	
Street*	Complete with provider business physical location
City*	

State/Province*	
ZIP Code/Postal Code*	9-digit Zip code of the Billing Provider as reported to Nebraska Medicaid is required.

PROVIDER IDENTIFIERS INFORMATION	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)*	
National Provider Identifier (NPI)	For Healthcare Providers: Required -- The 10-digit NPI of the provider, as reported to Nebraska Medicaid. For Atypical Providers: Leave blank.
Assigning Authority	NE Medicaid
Trading Partner ID	If known, enter the Nebraska Medicaid Trading Partner ID.
Provider Taxonomy Code	For Healthcare Providers: Required – 10-digit Taxonomy code, as reported to Nebraska Medicaid. For Atypical Providers: Leave Blank.

PROVIDER CONTACT INFORMATION	
Provider Contact Name*	Name of a contact in provider office for handling EFT issues.
Telephone Number	
Telephone Number Extension	
Email Address	An electronic mail address at which Nebraska Medicaid can contact the provider.
Fax Number	
FINANCIAL INSTITUTION INFORMATION	
Financial Institution Name*	Official name of the provider's financial institution
Street*	
City*	
State/Province*	
ZIP Code/Postal Code*	
Financial Institution Telephone Number	Recommended
Telephone Number Extension	

Financial Institution Routing Number*	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited.
Type of Account at Financial Institution (select one)*	Select either checking or savings to describe account to which EFT payments are to be deposited.
Provider's Account Number with Financial Institution*	Provider's account number at the financial institution to which EFT payments are to be deposited.
Account Number Linkage to Provider Identifier	Pre-determined by Nebraska Medicaid.
Provider Tax Identification Number (TIN)	Optional
National Provider Identifier (NPI)	Optional

SUBMISSION INFORMATION	
Reason for Submission (select one)*	
Include with Enrollment Submission (select one)*	Include either a Voided Check or a Bank letter with the Enrollment Submission.
AUTHORIZED SIGNATURE	
Written Signature of Person Submitting Enrollment[1]	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. Not required by Nebraska Medicaid. See [1] below.
Printed Name of Person Submitting Enrollment[1]*	The printed name of the authorized person submitting and attesting to the accuracy of the information on the form. See [1] below.
Printed Title of Person Submitting Enrollment*	
Submission Date*	

[1]By signing or completing "Printed Name of Person Submitting Enrollment", the submitting individual is attesting and acknowledging on behalf of the Nebraska Medicaid Provider listed above that:

- He or she is authorized to complete and submit this Enrollment Form.
- The information provided is accurate and true.

Submit completed form and attachment via secure Email, fax or mail to:

Department of Health and Human Services
Attn: Medicaid Provider Enrollment
PO Box 95026
Lincoln, NE 68509-5026

Fax: (402) 742-2373

Email: DHHS.MedicaidProviderEnrollment@nebraska.gov

- Direct questions to the Medicaid Inquiry Line at 877-255-3092.

- Instructions to submit via secure email are located at: http://dhhs.ne.gov/Pages/fin_ist_SecureMail.aspx

- It is the responsibility of the Provider to contact their financial institution to request the receipt of all data contained within the ACH information field (including the TRN Reassociation Trace Number) of the CCD+ Addenda Record. This Trace Number uniquely identifies the transaction set and aids in reassociating payments and remittance advices.

- Click "HERE" for Late/Missing EFT Resolution Procedures.